		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028134

Facility Name: Lakeview Living Center

Address: 7270 South Shore Drive (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: (773) 721-7700 **Fax #** (773) 721-9712

IDPA ID Number: 363234108001

Date of Initial License for Current Owners: 05/23/83

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	145	Intermediate/DD	145	52,925	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	47,483	350		47,833	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,483	350		47,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.38%

D. How many bed-hold days during this year were paid by Public Aid?
945 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/23/83

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	199,890	18,474	9,433	227,797		227,797		227,797			1
2	Food Purchase		212,071		212,071		212,071	(34,520)	177,551			2
3	Housekeeping	92,240	18,785		111,025		111,025		111,025			3
4	Laundry	45,535	19,910		65,445		65,445		65,445			4
5	Heat and Other Utilities			92,313	92,313		92,313		92,313			5
6	Maintenance	67,196		51,807	119,003		119,003		119,003			6
7	Other (specify):*											7
8	**TOTAL General Services**	404,861	269,240	153,553	827,654		827,654	(34,520)	793,134			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,929,694	16,100	39,589	1,985,383		1,985,383		1,985,383			10
10a	Therapy			21,023	21,023		21,023		21,023			10a
11	Activities		28,843	11,792	40,635		40,635		40,635			11
12	Social Services	17,555		13,775	31,330		31,330		31,330			12
13	Nurse Aide Training	61,236		14,381	75,617		75,617		75,617			13
14	Program Transportation			10,183	10,183		10,183		10,183			14
15	Other (specify):* Routine Dental			10,255	10,255		10,255		10,255			15
16	**TOTAL Health Care and Programs**	2,008,485	44,943	120,998	2,174,426		2,174,426		2,174,426			16
	C. General Administration											
17	Administrative	130,530		556,500	687,030		687,030		687,030			17
18	Directors Fees							26,819	26,819			18
19	Professional Services			3,083	3,083		3,083	64,844	67,927			19
20	Dues, Fees, Subscriptions & Promotions			12,097	12,097		12,097	1,790	13,887			20
21	Clerical & General Office Expenses	102,674	16,082	36,835	155,591		155,591	1,779	157,370			21
22	Employee Benefits & Payroll Taxes			349,477	349,477		349,477	179,732	529,209			22
23	Inservice Training & Education			704	704		704		704			23
24	Travel and Seminar			2,617	2,617		2,617	2,886	5,503			24
25	Other Admin. Staff Transportation			8,905	8,905		8,905	2,292	11,197			25
26	Insurance-Prop.Liab.Malpractice			1,277	1,277		1,277	41,629	42,906			26
27	Other (specify):*											27
28	**TOTAL General Administration**	233,204	16,082	971,495	1,220,781		1,220,781	321,771	1,542,552			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,646,550	330,265	1,246,046	4,222,861		4,222,861	287,251	4,510,112			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lakeview Living Center #0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			114,371	114,371		114,371	9,953	124,324			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			240,476	240,476		240,476	(347)	240,129			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			4,800	4,800		4,800		4,800			34
35	Rent-Equipment & Vehicles			19,453	19,453		19,453	96	19,549			35
36	Other (specify):*											36
37	**TOTAL Ownership**			379,100	379,100		379,100	9,702	388,802			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							4,026	4,026			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			255,471	255,471		255,471	85,157	340,628			42
43	Other (specify):* Nonallowable Costs			1,510,853	1,510,853		1,510,853	(1,510,853)				43
44	**TOTAL Special Cost Centers**			1,766,324	1,766,324		1,766,324	(1,421,670)	344,654			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,646,550	330,265	3,391,470	6,368,285		6,368,285	(1,124,717)	5,243,568			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(1,492,580)	43		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(126)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,608	30		9
10	Interest and Other Investment Income	(26,420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,644)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,748)	43		24
25	Fund Raising, Advertising and Promotional	(755)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending & Misc. Inc. offset	(4,624)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,534,289)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	409,572		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 409,572		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,124,717)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lakeview Living Center

ID# 0028134

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakeview Living Center **#** 0028134 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	8,638	18,181	0	0	0	0	0	0	0	0	26,819	18
19	Professional Services	0	21,339	43,505	0	0	0	0	0	0	0	0	64,844	19
20	Fees, Subscriptions & Promotions	0	956	15	0	0	0	0	0	0	0	0	971	20
21	Clerical & General Office Expenses	0	3,118	3,287	0	0	0	0	0	0	0	0	6,405	21
22	Employee Benefits & Payroll Taxes	0	73,649	72,382	0	0	0	0	0	0	0	0	146,031	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	955	1,929	0	0	0	0	0	0	0	0	2,884	24
25	Other Admin. Staff Transportation	0	2,292	0	0	0	0	0	0	0	0	0	2,292	25
26	Insurance-Prop.Liab.Malpractice	0	345	41,284	0	0	0	0	0	0	0	0	41,629	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	111,292	180,583	0	0	0	0	0	0	0	0	291,875	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	111,292	180,583	0	0	0	0	0	0	0	0	291,875	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakeview Living Center # 0028134 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,608	2,345	0	0	0	0	0	0	0	0	0	9,953	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,420)	2,614	23,459	0	0	0	0	0	0	0	0	(347)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	96	0	0	0	0	0	0	0	0	0	96	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(18,812)	5,055	23,459	0	0	0	0	0	0	0	0	9,702	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	4,026	0	0	0	0	0	0	0	0	0	4,026	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	85,157	0	0	0	0	0	0	0	0	85,157	42
43	Other (specify):*	(1,510,853)	0	0	0	0	0	0	0	0	0	0	(1,510,853)	43
44	**TOTAL Special Cost Centers**	(1,510,853)	4,026	85,157	0	0	0	0	0	0	0	0	(1,421,670)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,529,665)	120,373	289,199	0	0	0	0	0	0	0	0	(1,120,093)	45

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Residential Centers, Inc. - See attached Schedule 7A	100%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Board fees	$	Center for Residential Management, Inc.	**	$ 8,638	$ 8,638	1
2	V	19	Professional fees		Center for Residential Management, Inc.	**	21,339	21,339	2
3	V	20	Licenses, dues, & subs		Center for Residential Management, Inc.	**	956	956	3
4	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	3,118	3,118	4
5	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	73,649	73,649	5
6	V	24	Travel & seminar		Center for Residential Management, Inc.	**	955	955	6
7	V	25	Vehicle expense		Center for Residential Management, Inc.	**	2,292	2,292	7
8	V	26	Vehicle, fire & liab insurance		Center for Residential Management, Inc.	**	345	345	8
9	V	30	Depreciation		Center for Residential Management, Inc.	**	2,345	2,345	9
10	V	32	Interest expense		Center for Residential Management, Inc.	**	2,614	2,614	10
11	V	35	Vehicle lease		Center for Residential Management, Inc.	**	96	96	11
12	V	39	Ancillary service centers		Center for Residential Management, Inc.	**	4,026	4,026	12
13	V				Center for Residential Management, Inc.				13
14	Total			$			$ 120,373	$ * 120,373	14

**Center for Residential Management, Inc. is Residential Centers, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII - Related Parties **Related Party Schedule**
Page 6, Section A, Column 2, Related Nursing Homes

Name	Facility Name	City
Progressive Housing, Inc.	Gateway Terrace	Irvington
	Aviston Terrace	Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills (185th St.)	Country Club Hills
	Country Club Hills (Lee St.)	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon

Schedule VII, Related Parties
Page 6, Section A, Column 3, Other Related Business Entities

Name	City	Type of Business
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	18	Board fees	$	Residential Centers, Inc.	100.00%	$ 18,181	$ 18,181	15
16	V	19	Professional fees		Residential Centers, Inc.	100.00%	43,505	43,505	16
17	V	20	License, dues & subscriptions		Residential Centers, Inc.	100.00%	15	15	17
18	V	21	Office supplies & telephone		Residential Centers, Inc.	100.00%	3,287	3,287	18
19	V	22	Emp. benefits & payroll taxes		Residential Centers, Inc.	100.00%	72,382	72,382	19
20	V	24	Travel & seminar		Residential Centers, Inc.	100.00%	1,929	1,929	20
21	V	26	Vehicle, fire & liab insurance		Residential Centers, Inc.	100.00%	41,284	41,284	21
22	V	32	Interest expense		Residential Centers, Inc.	100.00%	23,459	23,459	22
23	V	42	Provider fees		Residential Centers, Inc.	100.00%	85,157	85,157	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 289,199	$ * 289,199	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Ronald Schroeder	President	Board Member	None	10,215	2 hrs/mtg.		Directors fees	$ 5,185	L18, C8	1
2	Darrell Boehne	Vice President	Board Member	None	10,366	2 hrs/mtg.		Directors fees	5,034	L18, C8	2
3	Edward Childers	Secretary	Board Member	None	10,115	2 hrs/mtg.		Directors fees	5,085	L18, C8	3
4	Robert Bauer	Treasurer	Board Member	None	8,966	2 hrs/mtg.		Directors fees	5,034	L18, C8	4
5	Merla McCloud	Recorder	Administrative	None	13,366	2 hrs/mtg.		Directors fees	5,034	L18, C8	5
6	Orland Bauer	Board Member	Board Member	None	8,953	2 hrs/mtg.		Directors fees	1,447	L18, C8	6
7											7
8											8
9											9
10											10
11											11
12	See Attached Schedule 7A										12
13								TOTAL	$ 26,819		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SCHEDULE 7A

Board of Directors Fees

	Ron Schroeder	Darrell Boehne	Edward Childers	Bob Bauer	Cora Flota	Orland Bauer	Kay Schuman Johnson	Roger Ryan	Ronald O'Daniell	William Armstrong	Kay Baker	Merla McCloud	Totals
Residential Centers, Inc.													
Lakeview Living Center	3,757	3,606	3,606	3,606								3,606	18,181
Sparta Terrace	415	398	398	398								398	2,006
Ellner Terrace	415	398	398	398								398	2,006
Taylorville Terrace	415	398	398	398								398	2,006
Total RCI	5,000	4,800	4,800	4,800	0	0	0	0	0	0	0	4,800	24,200
Progressive Housing, Inc.													
Aviston Terrace	553	576	553		553	553	282					553	3,623
Harris Place	553	576	553		553	553	282					553	3,623
Briarbrook Place	553	576	553		553	553	282					553	3,623
Joshua Manor	553	576	553		553	553	282					553	3,623
Terra Estates	553	576	553		553	553	282					553	3,623
Park Place	553	576	553		553	553	282					553	3,623
Okawville	207	216	207		207	207	106					207	1,358
Perrine	138	144	138		138	138	71					138	906
Western Gardens	138	144	138		138	138	71					138	905
Galaxy	276	288	276		276	276	141					276	1,811
Billy Goat Hill	276	288	276		276	276	141					276	1,811
Troy	138	144	138		138	138	71					138	906
Country Club Hills - 185th St.	207	216	207		207	207	106					207	1,357
Country Club Hills - Lee St.	101	101	101		101	101	0					101	608
Total PHI	4,800	5,000	4,800	0	4,800	4,800	2,400	0	0	0	0	4,800	31,400
Caravilla Resident Centers, Inc.													
Mt. Vernon				980				871	871	871	871	871	5,338
Jeffersonian Care Center				996				885	885	885	885	885	5,421
Casey Care Center				1,624				1,443	1,443	1,443	1,443	1,443	8,841
Total CRC	0	0	0	3,600	0	0	0	3,200	3,200	3,200	3,200	3,200	19,600
Center for Residential Management, Inc. *	5,600	5,600	5,600	5,600		5,600						5,600	33,600
Total Board of Directors Fees	15,400	15,400	15,200	14,000	4,800	10,400	2,400	3,200	3,200	3,200	3,200	18,400	108,800

* Center for Residential Management, Inc.'s board fees are allocated to each facility.

Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period.

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Center for Residential Management, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed days available	207,498	21	$ 7,680	$	52,925	$ 1,959	1
2	20	Licenses, dues, & subs	Bed days available	207,498	21	(100)		52,925	(26)	2
3	21	Office supplies & telephone	Bed days available	207,498	21	(861)		52,925	(220)	3
4	24	Travel & seminar	Bed days available	207,498	21	(580)		52,925	(148)	4
5	25	Vehicle expense	Bed days available	207,498	21	8,145		52,925	2,077	5
6	26	Vehicle, fire & liab insurance	Bed days available	207,498	21	1,353		52,925	345	6
7	30	Depreciation	Bed days available	207,498	21	9,194		52,925	2,345	7
8	32	Interest expense	Bed days available	207,498	21	8,154		52,925	2,080	8
9	35	Vehicle lease	Bed days available	207,498	21	375		52,925	96	9
10	39	Ancillary service centers	Bed days available	207,498	21	15,783		52,925	4,026	10
11										11
12										12
13	18	Board fees	Direct method						8,638	13
14	19	Professional fees	Direct method						19,380	14
15	20	Licenses, dues, & subs	Direct method						982	15
16	21	Office supplies & telephone	Direct method						3,338	16
17	22	Emp. benefits & payroll taxes	Direct method						73,649	17
18	24	Travel & seminar	Direct method						1,103	18
19	25	Vehicle expense	Direct method						215	19
20	32	Interest expense	Direct method						534	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 49,143	$		$ 120,373	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Residential Centers, Inc.
Street Address: 4239 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-8463

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Board fees	Number of beds	193	4	$ 24,199	$	145	$ 18,181	1
2	19	Professional fees	Number of beds, direct costs	193	4	58,219		145	43,505	2
3	20	License, dues & subscriptions	Number of beds	193	4	21		145	15	3
4	21	Office supplies & telephone	Number of beds, direct costs	193	4	7,768		145	3,285	4
5	22	Emp. benefits & payroll taxes	Number of beds	193	4	2,017		145	1,516	5
6	24	Travel & seminar	Number of beds	193	4	2,568		145	1,929	6
7	32	Interest expense	Number of beds, direct costs	193	4	74,026		145	23,461	7
8	42	Provider fees	Number of beds, direct costs	193	4	110,799		145	85,157	8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						70,866	10
11	26	Vehicle, fire & liab. insurance	Direct method						41,284	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 279,617	$		$ 289,199	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	IL Health Fac. Auth.-Bonds		X	Acquisition of Facilities	Annual Pymnt	12/01/92	$ 6,160,000	$ 2,707,801	08/15/16	0.0850	$ 226,816	1
2	Premier Capital Group, Inc.		X	Laundry Equipment	$175.00	10/05/99	6,942	3,873	10/05/04	0.1759	817	2
3	NCS Healthcare, Inc.		X	Software/Hardware	$358.00	10/01/98	14,307	4,770	09/30/03	0.1429	606	3
4	Effingham State Bank		X	Purchase of Vehicles	$1,083.74	06/24/02	23,986	11,459	05/30/04	0.0818	158	4
5												5
	Working Capital											
6	Community Bank of Galesburg		X	Line of Credit	None	08/23/02	308,000	143,000	02/23/02	0.0950	20,435	6
7												7
8												8
9	TOTAL Facility Related				$1,616.74		$ 6,513,235	$ 2,870,903			$ 248,832	9
	B. Non-Facility Related*											
10							Miscellaneous Interest Expense				7,395	10
11							Offset Interest Income & Non-allowable Interest Expense				(26,420)	11
12							Allocated from Parent Company				2,080	12
13							Amortization Expense				8,242	13
14	TOTAL Non-Facility Related						$	$			$ (8,703)	14
15	TOTALS (line 9+line14)						$ 6,513,235	$ 2,870,903			$ 240,129	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakeview Living Cente COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0028134

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,760 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 6

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	26,080	1988	$ 41,516	1
2					2
3	TOTALS	26,080		$ 41,516	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		1988	1910	$ 1,585,984	$ 45,314	35	$ 45,314	$	$ 615,410	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1983	5,047		10			5,047	9
10	Building Improvement			1984	42,110		15			42,110	10
11	Building Improvement			1985	102,043		10			102,043	11
12	Building Improvement			1986	23,799		20			23,799	12
13	Building Improvement			1987	30,173		20			30,173	13
14	Building Improvement			1990	94,921	7,637	15	7,637		87,581	14
15	Building Improvement			1991	700		10			700	15
16	Building Improvement			1992	9,135	609	15	609		5,659	16
17	Building Improvement			1993	112,022	9,898	15	9,898		86,400	17
18	Building Improvement			1993	115,471	7,698	15	7,698		65,433	18
19	Building Improvement			1994	35,926		10			35,926	19
20	Building Improvement			1995	32,918	2,195	15	2,195		16,040	20
21	Phone System			1996	23,095	2,310	10	2,310		14,819	21
22	Install Fire Hose			1995	1,228	82	15	82		539	22
23	Elevator Improvements			1996	3,356	224	15	224		1,417	23
24	Reception Area			1996	1,598	107	15	107		666	24
25	Two Sets of Steel Doors			1995	3,250	217	15	217		1,444	25
26	Cabinets in Reception Area			1995	3,500	233	15	233		1,536	26
27	Motor for Elevator			1996	2,042	136	15	136		805	27
28	Tub Resurfacing			1996	4,900	327	15	327		1,906	28
29	Concrete Ramp			1996	700	47	15	47		268	29
30	Roof Shaft & Exhaust			1996	1,110	74	15	74		426	30
31	Floor Drain			1997	2,300	153	15	153		818	31
32	Box Elevator			1997	1,950	130	15	130		672	32
33	Concrete Lunch Area			1997	4,313	288	15	288		1,485	33
34	Roof Work			1997	45,658	3,044	15	3,044		15,727	34
35	Box on Elevator			1998	525	35	15	35		172	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Lighting	1998	$ 2,715	$ 181	15	$ 181	$	$ 860	37
38	Plumbing	1998	700	47	15	47		210	38
39	Sprinkler System	1998	2,531	169	15	169		811	39
40	Rooftop Exhaust Fan	1998	635	42	15	42		194	40
41	Electric Door Strike	1998	582	39	15	39		191	41
42	Glass	1998	679	45	15	45		219	42
43	Carpet	1999	518	34	15	34		118	43
44	Door	1999	680	45	15	45		121	44
45	Bathroom renovations	2000	8,800	587	15	587		917	45
46	Plumbing	2001	2,100	140	15	140		163	46
47	Shower base and tiles	2001	2,200	147	15	147		147	47
48	Tuck pointing brick	2001	43,284	2,164	15	2,164		2,164	48
49	Steel doors	2002	1,430	40	15	40		40	49
50	Resurface bathtub	2002	1,120	25	15	25		25	50
51	Water line motor	2002	1,275	21	15	21		21	51
52	Elevator edge	2001	1,696	104	15	104		104	52
53	Elevator doors	2002	920	26	15	26		26	53
54	Water line	2002	1,750	10	15	10		10	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,363,389	$ 84,624		$ 84,624	$	$ 1,165,362	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 259,772	$ 23,505	$ 31,113	$ 7,608	5-10 Yrs.	$ 102,278	71
72	Current Year Purchases	67,215	5,562	5,562		5-10 Yrs.	5,562	72
73	Fully Depreciated Assets	521,584					521,584	73
74	Parent Company Allocation			2,345	2,345			74
75	TOTALS	$ 848,571	$ 29,067	$ 39,020	$ 9,953		$ 629,424	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	85 Dodge Van	2002	$ 2,800	$ 280	$ 280	$	5	$ 280	76
77	Resident Transportation	2002 Ford Van	2002	23,986	400	400		5	400	77
78										78
79										79
80	TOTALS			$ 26,786	$ 680	$ 680	$		$ 680	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,280,262	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 114,371	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,324	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,953	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,795,466	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Apartment rented for administrative use				4,800			5
6								6
7	TOTAL				$ 4,800 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 17,953 Description: Dishwasher $3,131; Copier $14,822
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	1992 Ford Van	$ 250.00	$ 1,500	17
18					18
19					19
20	Allocated Parent Company			96	20
21	TOTAL		$ 250.00	$ 1,596	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 12,631	$	$ 12,631
2	Books and Supplies		1,750		1,750
3	Classroom Wages (a)		61,236		61,236
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 75,617	$	$ 75,617
10	SUM OF line 9, col. 1 and 2 (e)	$ 75,617			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	70
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	70

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Mcr B Med Supplies	L39, C8					4,026		4,026	13
14	TOTAL			$		$	$ 4,026		$ 4,026	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,221	$ 4,221	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 98,800)	1,324,250	1,324,250	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,576	11,576	6
7	Other Prepaid Expenses	90,853	90,853	7
8	Accounts Receivable (owners or related parties)	3,853,596	3,853,596	8
9	Other(specify): See Attached Schedule 17A	423,253	423,253	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,707,749	$ 5,707,749	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	41,516	41,516	13
14	Buildings, at Historical Cost	1,585,984	1,585,984	14
15	Leasehold Improvements, at Historical Cost	741,479	777,405	15
16	Equipment, at Historical Cost	911,283	875,357	16
17	Accumulated Depreciation (book methods)	(1,785,792)	(1,795,466)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	510,240	510,240	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized Bond Fees	111,971	111,971	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,116,681	$ 2,107,007	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,824,430	$ 7,814,756	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 153,549	$ 153,549	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	237,801	237,801	29
30	Accrued Salaries Payable	112,462	112,462	30
31	Accrued Taxes Payable (excluding real estate taxes)	730	730	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	114,589	114,589	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	687,167	687,167	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,306,298	$ 1,306,298	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	20,102	20,102	39
40	Mortgage Payable			40
41	Bonds Payable	2,613,000	2,613,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,633,102	$ 2,633,102	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,939,400	$ 3,939,400	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,885,030	$ 3,875,356	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,824,430	$ 7,814,756	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lakeview Living Center
Provider #: 0028134
06/30/02

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Line 9 - Other Current Assets		
Prepaid Deposit	849	849
Due From Third Party	422,404	422,404
	423,253	423,253
Line 36 - Other Current Liabilities		
Accrued Expense	274,932	274,932
Accrued Workshop	359,800	359,800
Resident Credit Balances	44,845	44,845
PFL Life	1,009	1,009
Accrued Insurance Payable	6,581	6,581
	687,167	687,167

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,627,299	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(380,666)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,246,633	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,035,437	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Parent company allocation**	(397,040)	15
16	Other (describe) **(added back in column 7)**		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 638,397	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,885,030	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,824,247	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,824,247	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	1,492,580	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	62,604	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,555,184	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,025	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,025	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Vending income	5,266	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,266	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,403,722	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	827,654	31
32	Health Care	2,174,426	32
33	General Administration	1,220,781	33
	B. Capital Expense		
34	Ownership	379,100	34
	C. Ancillary Expense		
35	Special Cost Centers	1,510,853	35
36	Provider Participation Fee	255,471	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,368,285	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,035,437	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,035,437	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Residential Centers, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,054	2,166	$ 51,476	$ 23.77	1
2	Assistant Director of Nursing	2,366	2,548	40,945	16.07	2
3	Registered Nurses					3
4	Licensed Practical Nurses	15,583	16,940	269,900	15.93	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	8,400	8,400	61,236	7.29	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,850	2,054	17,555	8.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,303	25,091	199,890	7.97	15
16	Dishwashers					16
17	Maintenance Workers	5,298	5,714	67,196	11.76	17
18	Housekeepers	10,320	10,997	92,240	8.39	18
19	Laundry	4,459	4,960	45,535	9.18	19
20	Administrator	4,007	4,219	130,530	30.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,444	10,189	102,674	10.08	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	14,554	15,352	204,521	13.32	28
29	Resident Services Coordinator	3,311	3,617	62,438	17.26	29
30	Habilitation Aides (DD Homes)	143,046	153,603	1,300,414	8.47	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	247,995	265,850	$ 2,646,550 *	$ 9.96	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	205	$ 9,433	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	95	L10, C3	39
40	Physical Therapy Consultant	84	4,452	L10a, C3	40
41	Occupational Therapy Consultant	92	4,850	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	293	11,721	L10a, C3	43
44	Activity Consultant	80	11,792	L11, C3	44
45	Social Service Consultant	250	13,775	L12, C3	45
46	Other(specify)				46
47	Psychological Consultant	Monthly	39,494	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,004	$ 95,612		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eugene Humphrey	Administrator	0%	$ 78,261
John Mirecki	Administrator	0%	52,269
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,530

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc.-	$
Administrative Services	556,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 556,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 2,257
Lawrence Manson	Legal	826
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,083

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,866
Unemployment Compensation Insurance	64,059
FICA Taxes	202,655
Employee Health Insurance	128,037
Employee Meals	34,520
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	572
Pension Fund	26,503
Employee Morale	1,997
TOTAL (agree to Schedule V, line 22, col.8)	$ 529,209

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,664
Health Care Worker Background Check	819
(Indicate # of checks performed 117)	
Illinois Health Care Association Dues	6,463
Miscellaneous Licenses & Fees	2,872
Miscellaneous Dues & Subscriptions	895
Parent Company Allocation	(26)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,887

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,765
Seminar Expense	1,886
Parent Company Allocation	(148)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,503

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lakeview Living Center
Provider #:0028134
06/30/02

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		3,083
Allocated from Residential Centers, Inc.		
Lawrence Manson	Legal	6,957
Altschuler, Melvoin & Glasser, LLP	Accounting	36,548
Allocated from Parent Company		
American Express Tax & Business Services	Accounting	3,575
Altschuler, Melvoin & Glasser LLP	Accounting	3,604
Mangum, Smietanka & Johnson	Legal	6,123
Lawrence Manson	Legal	8,037
Total (agree to Schedule V, line 19, column 8)		67,927

See Accountants' Compilation Report

Residential Centers, Inc.
Legal Fees Allocation
June 30, 2002

Detailed legal invoice listing:

Lawrence Manson	1,840
Lawrence Manson	2,040
Lawrence Manson	1,500
Lawrence Manson	100
Lawrence Manson	100
Lawrence Manson	40
Lawrence Manson	180
Lawrence Manson	360
Lawrence Manson	380
Lawrence Manson	220
Lawrence Manson	2,500
	9,260

	Lakeview	Sparta	Ellner	Taylorville	Total
# of beds	145	16	16	16	193
Lawrence Manson	6,957	768	768	768	9,260
Total Legal Allocation	6,957	768	768	768	9,260

SEE ACCOUNTANTS' COMPILATION REPORT

Center for Residential Management, Inc.
Professional Fees Allocation
June 30, 2002

American Express Tax & Business Services	Accounting	13,626
Altschuler, Melvoin & Glasser LLP	Accounting	14,178
Heinold-Banwart	Accounting	24,092
Lawrence Manson	Legal	31,620
Amount allocated through CRM allocation		83,516

Detailed legal invoice listing

Lawrence Manson	3,260
Lawrence Manson	4,360
Lawrence Manson	1,300
Lawrence Manson	5,600
Lawrence Manson	360
Lawrence Manson	3,420
Lawrence Manson	500
Lawrence Manson	2,540
Lawrence Manson	1,980
Lawrence Manson	2,720
Lawrence Manson	1,700
Lawrence Manson	3,880
	31,620

	Lakeview	Countryview	Sparta	Ellner	Taylorville	Gateway	Aviston	Briarbrook	Harris	Joshua	Terra	Park Place	Perrine	Okawville	WGarden	Galaxy	Cardinal	BGHill	Troy	CCH 185th	CCH Lee St.	Mt. Vernon	Jeffersonian	Casey	TOTAL
bed days available	52,925	-	5,840	5,840	5,840	-	5,840	5,840	5,840	5,840	5,840	5,840	2,190	2,190	1,460	2,920	-	2,920	1,460	2,190	1,638	23,360	23,725	38,690	208,228
Alloc. Percentage	0.254169	0.000000	0.028046	0.028046	0.028046	0.000000	0.028046	0.028046	0.028046	0.028046	0.028046	0.028046	0.010517	0.010517	0.007012	0.014023	0.000000	0.014023	0.007012	0.010517	0.007866	0.112185	0.113938	0.185806	1.000000
American Express Tax & Business Services	3,575	-	382	382	382	-	382	382	382	382	382	382	143	143	96	191	-	191	96	143	107	1,529	1,553	2,532	13,626
Altschuler, Melvoin & Glasser LLP	3,604	-	398	398	398	-	398	398	398	398	398	398	149	149	99	199	-	199	99	149	112	1,591	1,615	2,634	14,178
Mangum, Smietanka & Johnson	6,123	-	676	676	676	-	676	676	676	676	676	676	253	253	169	338	-	338	169	253	190	2,703	2,745	4,476	24,092
Lawrence Manson	8,037	-	887	887	887	-	887	887	887	887	887	887	333	333	222	443	-	443	222	333	249	3,547	3,603	5,875	31,620
	21,339	-	2,342	2,342	2,342	-	2,342	2,342	2,342	2,342	2,342	2,342	878	878	586	1,171	-	1,171	586	878	657	9,369	9,516	15,518	83,516

See Accountants' Compilation Report

Lakeview Living Center, Inc.
Provider #: 0028134
06/30/2002

Line 24 Detail:

Education/Seminars	1,886
Admin Travel	1,532
Admin Lodging	1,905
Admin Meals	127
Seminar Travel	131
Seminar Lodging	70
	5,651
Parent Company Allocation	(148)
	5,503

See Accountants' Compilation Report

Facility Name & ID Number Lakeview Living Center # 0028134 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3		N/A											
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakeview Living Center # 0028134 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $6,463**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **340,628**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **34,520** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **48%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lakeview Living Center** **03:18 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,124,717	equal to	-1,124,717	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	240,129	equal to	240,129	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	124,324	equal to	124,324	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	4,800	equal to	4,800	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	19,549	equal to	19,549	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	75,617	equal to	75,617	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	21,023	equal to	21,023	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	4,026	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	827,654	equal to	827,654	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,174,426	equal to	2,174,426	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,220,781	equal to	1,220,781	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	379,100	equal to	379,100	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	1,510,853	equal to	1,510,853	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	255,471	equal to	255,471	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,929,694	equal to	1,929,694	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	61,236	< or = to	61,236	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,555	equal to	17,555	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	199,890	equal to	199,890	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	67,196	equal to	67,196	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	92,240	equal to	92,240	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	45,535	equal to	45,535	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	130,530	equal to	130,530	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	102,674	equal to	102,674	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,646,550	equal to	2,646,550	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,433	< or = to	9,433	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	0	< or = to		0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	95	< or = to	39,589	-39,494	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	11,792	< or = to	11,792	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	13,775	< or = to	13,775	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	130,530	equal to	130,530	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	556,500	equal to	556,500	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	3,083	equal to	3,083	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	529,209	equal to	529,209	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	13,887	equal to	13,887	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,503	equal to	5,503	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	340,628	equal to	255,471	85,157	FAILED	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	34,520	< or = to	179,732	-145,212	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	34,520	equal to	34,520	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	61,236	equal to	61,236	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	409,572	equal to	409,572	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,870,903	equal to	2,870,903	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	41,516	equal to	41,516	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,363,389	equal to	2,363,389	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	875,357	equal to	875,357	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,795,466	equal to	1,795,466	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,885,030	equal to	3,885,030	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	1,035,437	equal to	1,035,437	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	7,824,430	equal to	7,824,430	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	199,890	18,474	9,433	227,797	0	227,797	0	227,797
2. Food P	0	212,071	0	212,071	0	212,071	-34,520	177,551
3. Housek	92,240	18,785	0	111,025	0	111,025	0	111,025
4. Laundr	45,535	19,910	0	65,445	0	65,445	0	65,445
5. Heat ar	0	0	92,313	92,313	0	92,313	0	92,313
6. Mainter	67,196	0	51,807	119,003	0	119,003	0	119,003
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	404,861	269,240	153,553	827,654	0	827,654	-34,520	793,134
9. Medical	0	0	0	0	0	0	0	0
10. Nursin	1,929,694	16,100	39,589	1,985,383	0	1,985,383	0	1,985,383
10a. Ther	0	0	21,023	21,023	0	21,023	0	21,023
11. Activit	0	28,843	11,792	40,635	0	40,635	0	40,635
12. Social	17,555	0	13,775	31,330	0	31,330	0	31,330
13. Nurse	61,236	0	14,381	75,617	0	75,617	0	75,617
14. Progra	0	0	10,183	10,183	0	10,183	0	10,183
15. Other	0	0	10,255	10,255	0	10,255	0	10,255
16. Total H	2,008,485	44,943	120,998	2,174,426	0	2,174,426	0	2,174,426
17. Admin	130,530	0	556,500	687,030	0	687,030	0	687,030
18. Direct	0	0	0	0	0	0	26,819	26,819
19. Profes	0	0	3,083	3,083	0	3,083	64,844	67,927
20. Fees,	0	0	12,097	12,097	0	12,097	1,790	13,887
21. Clerica	102,674	16,082	36,835	155,591	0	155,591	1,779	157,370
22. Emplo	0	0	349,477	349,477	0	349,477	179,732	529,209
23. Inserv	0	0	704	704	0	704	0	704
24. Travel	0	0	2,617	2,617	0	2,617	2,886	5,503
25. Other	0	0	8,905	8,905	0	8,905	2,292	11,197
26. Insura	0	0	1,277	1,277	0	1,277	41,629	42,906
27. Other	0	0	0	0	0	0	0	0
28. Total (	233,204	16,082	971,495	1,220,781	0	1,220,781	321,771	1,542,552
29. Total (	2,646,550	330,265	1,246,046	4,222,861	0	4,222,861	287,251	4,510,112
30. Depre	0	0	114,371	114,371	0	114,371	9,953	124,324
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	240,476	240,476	0	240,476	-347	240,129
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	4,800	4,800	0	4,800	0	4,800
35. Rent -	0	0	19,453	19,453	0	19,453	96	19,549
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	379,100	379,100	0	379,100	9,702	388,802
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	0	0	0	0	0	4,026	4,026
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	255,471	255,471	0	255,471	85,157	340,628
43. Other	0	0	1,510,853	1,510,853	0	1,510,853	########	0
44. Total S	0	0	1,766,324	1,766,324	0	1,766,324	########	344,654
45. Grand	2,646,550	330,265	3,391,470	6,368,285	0	6,368,285	########	5,243,568

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	4,221	4,221
2. Cash - F	0	0
3. Account	1,324,250	1,324,250
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	11,576	11,576
7. Other Pr	90,853	90,853
8. Account	3,853,596	3,853,596
9. Other (s	423,253	423,253
10. Total c	5,707,749	5,707,749
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	41,516	41,516
14. Buildin	1,585,984	1,585,984
15. Leaseh	741,479	777,405
16. Equipn	911,283	875,357
17. Accum	-1,785,792	-1,795,466
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	510,240	510,240
22. Other l	0	0
23. other (s	111,971	111,971
24. Total L	2,116,681	2,107,007
25. Total A	7,824,430	7,814,756
CURRENT LIABILITIES		
26. Accour	153,549	153,549
27. Officer'	0	0
28. Accour	0	0
29. Short-T	237,801	237,801
30. Accrue	112,462	112,462
31. Accrue	730	730
32. Accrue	0	0
33. Accrue	114,589	114,589
34. Deferre	0	0
35. Federa	0	0
36. Other (	687,167	687,167
37. Other (	0	0
38. Total C	1,306,298	1,306,298
LONG TERM LIABILITES		
39.Long-Te	20,102	20,102
40.Mortgag	0	0
41.Bonds I	2,613,000	2,613,000
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	2,633,102	2,633,102
46.Total Li	3,939,400	3,939,400
47.Total Eq	3,885,030	3,875,356
48.Total Li	7,824,430	7,814,756

		Balance per Medicaid Trial Balance
1.	Gross F	5,824,247
2.	Discour	0
	Subtota	5,824,247
4.	Day Ca	0
5.	Other C	0
6.	Therapy	0
7.	Oxygen	0
	Subtota	-
9.	Paymer	1,492,580
10.	Other	0
11.	Nurses	62,604
12.	Gift an	0
13.	Barber	0
14.	Non-P	0
15.	Teleph	0
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	0
22.	Laund	0
	Subtot	1,555,184
24.	Contril	0
25.	Interes	19,025
	Subtot	19,025
27.	Other	0
28.	Other	5,266
	Subtot	5,266
30.	Total F	7,403,722
31.	Gener	827,654
32.	Health	2,174,426
33.	Gener	1,220,781
34.	Owner	379,100
35.	Specia	1,510,853
35.	Provid	255,471
37.	Other	0
40.	Total E	6,368,285
41.	Incom	1,035,437
42.	Incom	0
43.	Net In	1,035,437

Page

Line 16 for mortgage insurance.